

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BD*

CERTIFICATE OF DEATH

12132

Reg. Dist. No. *1620*

1. PLACE OF DEATH:

County *Garrett*
City or town *Grantsville, Md.*
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) *10 yrs.*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Garrett*
City or town *Grantsville* Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Bertha Beachy

3. (b) Social Security Number
None

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*

6. (b) Name of husband *xxx Christ C. Beachy*
6(c) If alive, give age *76* years

7. Birth date of deceased (mo., day, yr.) *November 21, 1880*

8. AGE: Years *66* Months *21* Days *hrs. min.*

9. Birthplace *Grantsville, Md.*
(Town, county, and state)

10. Usual occupation *Housewife*

11. Industry or business

12. Name *Jonas Gnagey*

13. Birthplace *Rural Accident, Md.*

14. Maiden name *Elizabeth Swauger*

15. Birthplace *New Germany, Md.*

16. Informant *William Gnagey*

Address *RD Meyersdale Pa*

17. *Burial* Date thereof *Nov. 15, 1946*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Grantsville*

Location *Grantsville, Md.*

18. Funeral director *Wm Winterburg*

Address *Grantsville, Maryland*

19. *Dec 20 46 Ethel Broadwater*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *December 12 1946* at *2:30 PM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Spanned after death*
and that I last saw him *alive on* 19

Immediate cause of death *Chronic Myocarditis*

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE *E. J. Baumgartner M.D.*

Address *Oakland Ind* Date signed *12/19/46*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *JD*

CERTIFICATE OF DEATH

12133

Reg. Dist. No. *1620*

1. PLACE OF DEATH:

County *Garett*
City or town *R.D.I. Grantsville*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *40 Years*
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State *Md* County *Garett*
City or town *R.D.I. Grantsville Md*
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Noxah E. Hershberger

3. (b) Social Security Number

None

4. Sex *Male* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Married*
6.(b) Name of husband or wife *Savilla Hershberger*
6.(c) If alive, give age *69* years
7. Birth date of deceased (mo., day, yr.) *March 12, 1865*
8. AGE: Years *81* Months *9* Days *15* If less than one day
hrs. min.

9. Birthplace *Rural Near Salisbury Pa*
(Town, county, and state)
10. Usual occupation *Retired Farmer*

11. Industry or business

12. Name *Emanuel Hershberger*
13. Birthplace *Rural Near Salisbury Pa*
14. Maiden name *Mary Miller*
15. Birthplace *R.D.I. Grantsville Md*

16. Informant *Mrs Sady Schrock*
Address *Grantsville Md*

17. Burial Date thereof *12-29-1946*
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory *Flag Run*
Location *R.D.I. Salisbury Pa*

18. Funeral director *Wm Winterberg*
Address *Grantsville Md*

19. *Dec 28 1946* *Ethel Broadwater*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *December 26 1946* at *6 p.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Dec 25 1946* to *Dec 26 1946*
and that I last saw him alive on *Dec 25 1946*

Immediate cause of death
Coronary artery disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *M. R. Davis*

Address *Grantsville Md* Date signed *Dec 28 1946*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH ★

2411 N. Charles St., Baltimore 73-2

CERTIFICATE OF DEATH

12134

Reg. Dist. No. 1620

1. PLACE OF DEATH:

County Garett
 City or town R.D.2 Grantsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 23 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Garett
 City or town R.d.2.Grantsville Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Lewis Kamp

3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Cora Ellen Kamp
 B.(c) If alive, give age 77 years
 7. Birth date of deceased (mo., day, yr.) September 14-1863
 8. AGE: Years 83 Months 2 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace R.D.Accident Md
 (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business _____

MOTHER FATHER 12. Name Henry Kamp
 13. Birthplace Germany

14. Maiden name Not Known

15. Birthplace Germany

16. Informant Mrs. Emma Otto

Address R.D.2 Grantsville Md

17. Burial Date thereof 12-5-1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cove

Location Rural Near Accident Md

18. Funeral director Wm. A. Winterberg

Address Grantsville Md

19. Dec 4 19 46 Ethel Broadwater
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 19 46 at 9 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 46 to Dec 2 19 46 and that I last saw him alive on Nov 20 19 46

Immediate cause of death Cerebral Myocarditis DURATION 3 yrs

Due to _____

Due to _____

Other conditions Cerebral Myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE M. R. Davis M.D. M. D. or other

Address Grantsville Md Date signed Dec 3

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12135

Reg. Dist. No. 1620

1. PLACE OF DEATH:

County... GarettCity or town... Grantsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... GarettCity or town... Grantsville
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Fredrick Livengood

3. (b) Social Security Number

218-07-8905

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MWMarried6.(b) Name of husband or wife Mary E. Livengood6.(c) If alive, give age 55 years7. Birth date of deceased (mo., day, yr.) April 2-18878. AGE: Years 59 Months 20 8 Days 25 If less than one day
.....hrs.min.9. Birthplace Grantsville Md
(Town, county, and state)10. Usual occupation Plummer

11. Industry or business

12. Name Christain Livengood13. Birthplace Near Salisbury Pa14. Maiden name Jennie Ubrich15. Birthplace Mount Pleasant Pa16. Informant Paul LivengoodAddress Washington D.C17. Burial Date thereof 12-30-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory GrantsvilleLocation Grantsville Md18. Funeral director Wm. WintersburgAddress Grantsville Md19. Dec 28 1946 Ethel Broadwater
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1946 at 4:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to Dec 27 1946 and that I last saw him alive on Dec 27 1946

Immediate cause of death

Brain aneurysm
ruptured

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

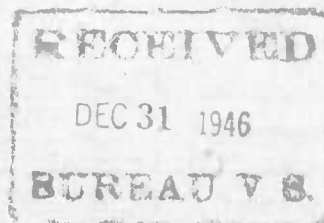
23. SIGNATURE

W. R. Davis
M. D. Other Dec 28 1946
Address Grantsville Md Date signed Dec 28 1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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Permanently

AMERICAN LEADER

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 926

CERTIFICATE OF DEATH

12136

Reg. Dist. No. 1660

1. PLACE OF DEATH:

County Garrett
 City or town Mt. Lake Park, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Several Years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town Mt. Lake Park, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Lois Marlyn Shaffer.

3. (b) Social Security Number

None.

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single.
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) August 20th, 1932.
 8. AGE: Years 14 Months 4 Days 11 If less than one day _____ hrs. _____ min.

8. Birthplace Freeport, W. Va.
 (Town, county, and state)
 10. Usual occupation Student.
 11. Industry or business _____

MOTHER FATHER
 12. Name Jay Shaffer.
 13. Birthplace Brookside, W. Va.
 14. Maiden name Dora Selders.
 15. Birthplace Brookside, W. Va.

18. Informant Mrs. Joe Rice.
 Address Mt. Lake Park, Md.

17. Burial Jan. 3/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Brookside Cemetery.
 Location Brookside, W. Va.

18. Funeral director Emory B. Bolden
 Address Baltimore, Md.

19. Jan. 3 19 47 Julia A. Rowan
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P.M.

20. DATE OF DEATH December 31st, 19 46, at 7:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 19 46 to Dec 31 19 46
 and that I last saw him alive on Dec 31 19 46

Immediate cause of death Myocardial failure during
 DURATION _____

Due to nutritional status insufficient

Due to Rheumatic fever

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE James A. Gannon M.D.
O. Oakland Address _____

Date signed Jan 2 '46

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

MEMORANDUM FOR THE ATTORNEY GENERAL

SUBJECT: [Illegible]

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N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County GarretteVillage or City Friendsville R F D,Registration Dist. No. 12137
1618

No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME Liddia N Sisler

(a) Residence: No. _____

St. _____

Ward. _____

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)
Widow5a. If married, widowed, or divorced
HUSBAND or
(or) WIFE of _____

6. DATE OF BIRTH (month, day, and year)

Oct 21 1871

7. AGE

Years

74

Months

3

Days

21

If LESS than

1 day, _____ hrs.
or _____ min.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.House work9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.Home10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (city or town)
(State or country)West Virginia
Preston Co

FATHER

13. NAME

David Beeghley14. BIRTHPLACE (city or town)
(State or country)West Virginia

MOTHER

15. MAIDEN NAME

Amanda Bromhd16. BIRTHPLACE (city or town)
(State or country)Preston CO
West Virginia17. INFORMANT
(Address)Arch C Friend
Friendsville, R D

18. BURIAL, CREMATION, OR REMOVAL

Place Sisler Cem., W. Va. Date 12/15, 194619. UNOBTAINER
(Address)E. G. Harred
Brandonville, Mo.

20. FILED

Dec 13, 1946 Kathryn Fike.
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

Dec1246

(Month)

(Day)

(Year)

22.

I HEREBY CERTIFY, That I attended deceased from

Sept, 1946, to Dec, 1946I last saw her alive on Sept 10, 1946; death is saidto have occurred on the date stated above, at 4 P m.The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:Chronic Myocarditis

Date of onset

1945

Other Contributory Causes of Importance:

Name of operation

none

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicida? _____ Date of injury _____, 19____

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Milton Tepper

M. D.

(Address)

Friendsville, Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis

Chronic interstitial nephritis

Cerebral hemorrhage

Date of onset

1915

1921

July 5, 1927

Other contributory causes of importance:

Gallstones

May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy

Run over by street car

Peritonitis

Date of onset

1 week ago

1 week ago

3 days ago

Other contributory causes of importance:

Gastroenteritis

1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12577

Reg. Dist. No. 1721

1. PLACE OF DEATH County <u>Garrett</u> <u>Kitzmiller</u> City or town (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>2 yrs.</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Garrett</u> <u>Kitzmiller</u> City or town (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION) 2.(a) If veteran, name war			
3. (a) FULL NAME <u>Ezra Russell Warnick</u>				3. (b) Social Security Number <u>196-09-6802</u>			
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Widowed</u>			
6. (b) Name of husband or wife <u>Lucinda Hazel (Bowser) Warnick</u>				6. (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>September 17, 1894</u>				8. AGE: Years <u>52</u> Months <u>2</u> Days <u>18</u> It less than one day hrs. min.			
9. Birthplace <u>Chestnut Grove, Garrett Co., Md.</u> (Town, county, and state)							
10. Usual occupation <u>Miner</u> <u>Coal Mines</u>							
11. Industry or business							
12. Name <u>Henry Bowse Warnick</u>				13. Birthplace <u>Chestnut Grove, Garrett Co., Md.</u>			
14. Maiden name <u>Clarice Beavers</u>				15. Birthplace <u>Mrs. Cecil Pyles</u> <u>Kitzmiller, Md.</u>			
16. Informant Address							
17. Burial Date thereof <u>Dec. 8, 1946</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Turner Cemetery</u> <u>Near Mt. Zion, Garrett Co., Md.</u> Location Otha F. Sharpless 18. Funeral director Address <u>Blaine, W.Va.</u>							
19. <u>12/5</u> <u>46</u> <u>AWB</u> (Date read by registrar) Registrar							
MEDICAL CERTIFICATION 20. DATE OF DEATH December 5 46 3P. 19 at M							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Dec. 1</u> 19 <u>46</u> to <u>Dec. 5</u> 19 <u>46</u> and that I last saw him alive on <u>Dec. 5</u> 19 <u>46</u> Immediate cause of death <u>Patent Bowdler-Pneumonia</u> Due to <u>Pulmonary T.B.</u> Other conditions (Include pregnancy within 3 months of death) Major findings of operations Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?							
23. SIGNATURE <u>Ralph Culandrella m.d.</u> Address <u>Kitzmiller, Md.</u> M. D. or other Date signed <u>Dec. 5-46</u>							

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